

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09907  
9911 CERTIFICATE OF DEATH Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2001 Virginia Ave.,			d. STREET ADDRESS 1 2001 Virginia Ave.,		
3. NAME OF DECEASED (Type or print) Catherine			First V	Middle Adams	Last 4. DATE OF DEATH Month 9 Day 13 Year 19 57
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1875	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Dallas Gaver			14. MOTHER'S MAIDEN NAME Mary Ellen Hessong		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Marion Adams, 2001 Va. Ave. Hagerstown, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Hypertension & Arterio sclerotic cardio-vascular disease with myocardial failure 5 yrs +		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County) (State)
21. I certify that I attended the deceased from Feb. 1957 to 13 Sept. 1957, that I last saw the deceased alive on 13 Sept. 1957, and that death occurred at 12:00 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE FF L Lusby	M.D. 2301 Monroe Hagerstown MD				ADDRESS (Street, city or town, state) 13 Sept. 1957 DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-15-1957	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven	22d. LOCATION (City, town, or county) Hagerstown	(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle			ADDRESS Myersville, Md.	24a. REC'D BY REGISTRAR Sept. 16, 1957	24b. REGISTRAR'S SIGNATURE Frank Powers

## BUREAU V. 5

18 SEP 1957

REFUGEE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 9949 CERTIFICATE OF DEATH

09908

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b>		b. COUNTY <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>49 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>24 E. Green St.,</b>		d. STREET ADDRESS <b>24 E. Green St.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Ira Thurman Angle</b>		First <b>Ira</b>	Middle <b>Thurman</b>
4. DATE OF DEATH <b>9</b>	Month <b>9</b>	Day <b>9</b>	Year <b>19 57</b>
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 20, 1887</b>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
9. AGE (In years lost birthday) <b>70 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Victor Products</b>	12. BIRTHPLACE (State or foreign country) <b>Claylick, Penna.</b>
13. FATHER'S NAME <b>Martin Luther Angle</b>	14. MOTHER'S MAIDEN NAME <b>Amanda C. Hawbaker</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>214-09-7879</b>	17. INFORMANT <b>Mrs. Etha Angle</b>	Address <b>Funkstown, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Arterio-sclerosis</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 6</b> , 1957, to <b>Sept 9</b> , 1957, that I last saw the deceased alive on <b>Sept 9</b> , 1957, and that death occurred at <b>8:47</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ADDRESS (Street, city or town, state)</b> ACTUAL SIGNATURE <b>Sidney Novakovic</b> PHYSICIAN'S NAME (Type) <b>SIDNEY NOVAKOVIC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>9-12-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill</b>
22d. LOCATION (City, town, or county) <b>Hagerstown</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	24a. REC'D BY REGISTRAR <b>Sept. 12, 1957</b>
			24b. REGISTRAR'S SIGNATURE <b>Frank Bowers</b>

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SEP 13 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 F11mc221 10-7-57 et

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9912

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83 Middletown Hagerstown	
3. NAME OF DECEASED (Type or print) Amanda		d. STREET ADDRESS 217 North Locust St. Methodist Home	
4. DATE OF DEATH Bailey		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX female white		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1874	
9. AGE (in years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Barncord		14. MOTHER'S MAIDEN NAME Sarah Dennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. J. W. Barncord		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Hypertensive cardiovascular disease		Indefinite	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 24, 1951, to Sept. 24, 1957, that I last saw the deceased alive on Sept. 24, 1957, and that death occurred at 2:45 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 148 West Washington St. Hagerstown, Maryland DATE SIGNED 9/25/57	
ACTUAL SIGNATURE B. B. Kneisley, M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-27-57	
22c. NAME OF CEMETERY OR CREMATORIUM Broadfording		22d. LOCATION (City, town, or county) Broadfording (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D. BY REGISTRAR Date 9/26/1957		24b. REGISTRAR'S SIGNATURE Robert Beavers	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

09910  
Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEEDYSVILLE</b>	RURAL <b>X1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>KEEDYSVILLE MD.R.1</b>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>BABY BOY BAKER</b>	First <b>BABY</b>	Middle <b>BOY</b>	Lost 4. DATE OF DEATH <b>SEPTEMBER 8 1957</b>	Month Day Year		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 8 1957</b>	9. AGE (In years lost birthday) yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>	11. BIRTHPLACE (State or foreign country) <b>HAGERSTOWN WASH.CO.MD.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>RALPH BAKER</b>	14. MOTHER'S MAIDEN NAME <b>BERNICE ANN REMSBURG</b>			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>RALPH BAKER KEEDYSVILLE MD.R.1.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.4</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>congenital heart and atelectasis</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Omphalocele</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)
21. I certify that I attended the deceased from <b>Sept 8, 1957</b> to <b>Sept 8, 1957</b> that I last saw the deceased alive on <b>Sept. 8, 1957</b> , and that death occurred at <b>12 noon</b> from the causes and on the date stated above.						
ACTUAL SIGNATURE <b>J.W. Done</b>	M.D.			ADDRESS (Street, city or town, state) <b>Sept. 9, 1957</b>		
DATE SIGNED						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>SEPT. 9 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>MOUNTAIN VIEW CEMETERY SHARPSBURG WASH.CO.MD.</b>	22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Boat Funeral Home</b>		ADDRESS <b>Bowdoin Md.</b>	24a. REC'D BY REGISTRAR <b>Sept. 12, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Frank Bowers</b>		

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SEP 13 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9914

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE				
Washington MARYLAND		Maryland Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 34 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 620 North Prospect St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
3. NAME OF DECEASED (Type or print)		First	Middle			
LIZZIE		MAUDE	BLICKENSTAFF			
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH			
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	August 30, 1879			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Frederick County, Md.			
13. FATHER'S NAME Josephas Palmer		14. MOTHER'S MAIDEN NAME Manzell Rice				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT			
No		None	Mrs. Ray Blume			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH				
Vascular Hypertension 331X		20 yrs				
DUE TO Acute Cerebral Hemorrhage		10 days				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b)				
DUE TO		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
None						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
None		None				
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a. m. p. m.	None 19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	none	-	-	-
21. I certify that I attended the deceased from July 1954, to Sept. 2, 1957, that I last saw the deceased alive on Sept. 2, 1957, and that death occurred at M, from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) DATE SIGNED						
ACTUAL SIGNATURE S. Robert Wells M.D. 115 N. Potomac Street 9-3-57						
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D. Hagerstown, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 4, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown	(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						
Rest Haven Funeral Chapel Inc. 1601 Penne, Ave. Hagerstown, Md.						
24a. REC'D BY REGISTRAR Sept. 3, 1957, Blanche Powers						
24b. REGISTRAR'S SIGNATURE						

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9915

## CERTIFICATE OF DEATH

09912

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>50 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>	
d. STREET ADDRESS <b>736 MARYLAND AVE.</b>		d. STREET ADDRESS <b>736 MARYLAND AVE.</b>	
e. IS RESIDENCE ON AFARNS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>EFFIE</b>	Middle <b>MYRTLE</b>	Last <b>BOWMAN</b>
4. DATE OF DEATH	Month <b>SEPT.</b>	Day <b>23</b>	Year <b>19 57</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>11/22/1872</b>
8. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>84 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL R. BURNS</b>		14. MOTHER'S MAIDEN NAME <b>?? SHUTZ</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. ALVEY B. BOWMAN</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>572.1</b> <i>Diverticulitis of Colon (2) mesenteric</i> DUE TO <i>Hemorrhoids</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>(2) Arteriosclerosis</b> DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b>	
		3 years -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>HAGERSTOWN</b> (County) <b>MARYLAND</b> (State) <b>M.D.</b>	
21. I certify that I attended the deceased from <b>9/16</b> , 19 <b>57</b> , to <b>9/23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/22</b> , 19 <b>57</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George Jennings</i>		ADDRESS (Street, city or town, state) <b>136 W. Washington St</b> (Date signed) <b>9/23/57</b>	
PHYSICIAN'S NAME (Type) <b>George Jennings</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/25/57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) <b>HAGERSTOWN</b> (State) <b>M.D.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norman, Hagerstown, Md.</i>		24a. REC'D. BY REGISTRAR <b>Sept. 27, 1957</b> <i>B. H. Bowers</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

OCT 1 1957

RECEIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9916

## CERTIFICATE OF DEATH

09913

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>8 Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>37 Mealey Pkwy</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Wash. County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>PAUL</b>		First <b>STEWART</b>	Middle <b>BOWMAN</b>	Lost	4. DATE OF DEATH <b>September 24 1957</b>	Month <b>September</b>	Day <b>24</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feby 28 1923</b>	9. AGE (In years last birthday) <b>35</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hag Lumber Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Hagerstown Wash. Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Frank S. Bowman Sr</b>		14. MOTHER'S MAIDEN NAME <b>Maude E. Stewart</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. # 2 315-18-1123</b>		17. INFORMANT <b>Mrs Ella S. Bowman 37 Mealey Pkwy</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>292.4</b>		DUE TO <i>Aplastic Anemia</i>		Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)		
21. I certify that I attended the deceased from Sept. 23, 1957, to Sept. 24, 1957, that I last saw the deceased alive on Sept. 23, 1957, and that death occurred at 1:10 A.M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>9/25/57</b>		
ACTUAL SIGNATURE <i>M. Kneisley</i>								
PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		Hagerstown, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 9/26/57</b>		22b. DATE THEREOF <b>9/26/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Sept. 26, 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Robert Powers</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU U. S.

SEP 30 1957

# REGELY EU

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9917

## CERTIFICATE OF DEATH

09915

Reg. Dist. No. 3026

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 81	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. STREET ADDRESS 111 Elizabeth St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Premature Baby Girl		First Bussard	Middle Name Month Day Year Middle 9 9 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-57
9. AGE (In years from birth) yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baby		10b. KIND OF BUSINESS OR INDUSTRY baby	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? Hagerstown, Md.	
13. FATHER'S NAME Raymond Bussard		14. MOTHER'S MAIDEN NAME Dorothy May Bowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT none Raymond Bussard Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED p. m. 19 While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/9/1957</u> to <u>9/9/1957</u> that I last saw the deceased alive on <u>9/9/1957</u> , and that death occurred at <u>7:10 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, City or town, state) M.D. 3026 N. Potomac St. Hagerstown, Md. 9/11/57	
ACTUAL SIGNATURE <u>A.M. Bacon Jr.</u>		DATE SIGNED 9/11/57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-57	
22c. NAME OF CEMETERY OR CREMATORIAL Brodafording Ch. of God		22d. LOCATION (City, town, or county) Broadfording (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.		ADDRESS 24a. REGD BY REGISTRAR Sept. 12, 1957	
		24b. REGISTRAR'S SIGNATURE <u>Robert G. Green</u>	

## BUREAU A.

SEP 13 1957

REGELY ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9950

## CERTIFICATE OF DEATH

09914  
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clear Spring R # 1</b>		c. LENGTH OF STAY IN lb <b>6 Yrs</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clear Spring R # 1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Broadfording Road</b>		d. STREET ADDRESS <b>Broadfording Rd</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ANNIE</b>		First <b>LAURIE</b>	Middle <b>BUSSARD-THOMAS</b>	Lost <b></b>	4. DATE OF DEATH <b>Sep tember 15 1957</b>	Month <b>19</b>	Day <b></b>	Year <b></b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept 30 1858</b>	9. AGE (In years at birthday) <b>98</b> yrs.	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS. Days <b></b>	12. IF UNDER 24 HRS. Hours <b></b>	13. IF UNDER 24 HRS. Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>George F. Heyser</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Artz</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Ora A. Ernst</b>		Address <b>Clearspring Md R # 1</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>		DUE TO <b>Cardiac Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO <b>Arterial Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Hagerstown Wash. Co</b>	(County) <b>Md.</b>	(State) <b>USA</b>				
21. I certify that I attended the deceased from <b>Jan 1, 1957</b> to <b>Sept 15 1957</b> , that I last saw the deceased alive on <b>Sept 15, 1957</b> , and that death occurred at <b>1105</b> M, from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>David R. Brewer</b>		M.D.		ADDRESS (Street, city or town, state) <b>Clearspring Md</b>		DATE/SIGNED <b>9/18/57</b>					
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/18/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md.</b>		(State) <b>USA</b>						
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>Joseph Murray</b>	24b. REGISTRAR'S SIGNATURE							
			DATE <b>SEP 23 1957</b>								

## CERTIFICATE OF DEATH

BUREAU V.

MD 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09916

9951 CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b>		b. COUNTY <b>WASHINGTON</b>	
c. LENGTH OF STAY IN lb <b>45 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 BOONSBORO</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SOUTH MAIN STREET</b>		d. STREET ADDRESS <b>1 SOUTH MAIN STREET</b>	
3. NAME OF DECEASED (Type or print) <b>SARAH RUTH BUTTS</b>		4. DATE OF DEATH Month Day Year <b>SEPT. 5 1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 9 1877</b>
9. AGE (In years lost birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MIDDLETOWN FRED. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN YOUNKINS</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH REEDER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. JOHN HALLER BOONSBORO MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 5</b> , 1957, to <b>Sept 5</b> , 1957, that I last saw the deceased alive on <b>Sept 4</b> , 1957, and that death occurred at <b>9 P.M.</b> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Boonsboro</b>	
ACTUAL SIGNATURE <b>G. W. Haller</b>		DATE SIGNED <b>9/7/57</b>	
PHYSICIAN'S NAME (Type) <b>G. W. Haller</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>SEPT. 8 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>GREEN HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MARTINSBURG W. VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>Sep 8 1957</b>	
ADDRESS <b>Boonsboro MD</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Paul</b>	

REGELIVE

SEP 11 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9918

## CERTIFICATE OF DEATH

09917

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Maryland		d. STREET ADDRESS 112 W. Potomac St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		9/5/57		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Patsy	Middle Ann	Last Campbell	4. DATE OF DEATH Sept. 14 1957	Month Sept.	Day 14	Year 1957	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Sept. 1 1956	9. AGE (In years lost birthday) 1 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 14	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Roy Lacy Campbell		14. MOTHER'S MAIDEN NAME Carrie Belle Ardingier							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Roy Campbell		112 W. Potomac St. Address Williamsport Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		b. (b) DUE TO c. (c)		INTERVAL BETWEEN ONSET AND DEATH Atrusia of Biliary System (Congenital) 1 yr Ascites, Hydrothorax & Enuresis 1 week					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D.		(County) 302 W. Potomac St.	(State) Md.
21. I certify that I attended the deceased from <u>Birth</u> , 19 <u>56</u> , to <u>9/14/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/14/57</u> , 19 <u>57</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>G. M. Bacon Jr.</u>				ADDRESS (Street, city or town, state) <u>302 W. Potomac St.</u>					DATE SIGNED <u>9/16/57</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 17-57		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Williamsport Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edith L. Leaf		ADDRESS Williamsport Md.		24a. REC'D BY REGISTRAR DATE Sept. 16, 1957		24b. REGISTRAR'S SIGNATURE Shatt. Bowers			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09918

9919

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1875 Jefferson Blvd.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
3. NAME OF DECEASED (Type or print) <b>Robert</b>		First <b>Robert</b>	Middle <b>Nelson</b>
3. NAME OF DECEASED (Type or print) <b>Robert</b>		Last <b>Chaney</b>	4. DATE OF DEATH 9 19 Day Year 19 57
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-27-1920</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lay out man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Aircraft</b>	11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>
13. FATHER'S NAME <b>Henry M. Chaney</b>		14. MOTHER'S MAIDEN NAME <b>Bertha I Chaney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. II 217-12-2151</b>	17. INFORMANT <b>Mrs. Mina J. Chaney</b>
		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkin's Disease.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 1/2 years</b>	
201X Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 13, 1951</b> to <b>Sept. 19, 1957</b> , that I last saw the deceased alive on <b>Sept. 16, 1957</b> , and that death occurred at <b>6:20 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>R. A. Bell</i>		ADDRESS (Street, city or town, state) <b>119 North Potomac St.</b> DATE SIGNED <b>9-20-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>9-22-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>River View</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	24a. REC'D. BY REGISTRAR DATE <b>Sept. 23, 1957</b>
			24b. REGISTRAR'S SIGNATURE <b>Chas. H. Beavers</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

SEP 25 1957

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REF ID: A1234567890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 9920 Item 16 Form C220 9-13-57 et  
**CERTIFICATE OF DEATH**

09919  
 Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>18 Hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>1201 Hamilton Blvd</b>	
3. NAME OF DECEASED (Type or print) <b>NELLE</b>		First <b>PAULINE</b>	Middle <b>CLOPPER</b>
4. DATE OF DEATH <b>Sept 5 1957</b>	Month <b>19</b>	Day <b>1957</b>	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct 26 1885</b>
9. AGE (In years last birthday) <b>71 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash. Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William O. Clopper</b>		14. MOTHER'S MAIDEN NAME <b>Susan Baker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-32-5885</b>	
17. INFORMANT <b>Dr Evelyn C. Luke 1201 Hamilton Blvd</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Coronary Thrombosis</b>			
(b) <b>Arteriosclerotic Heart Disease</b>		DUE TO <b>2 yrs.</b>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 5</b> , 1957, to <b>Sept 5</b> , 1957, that I last saw the deceased alive on <b>Sept 5</b> , 1957, and that death occurred at <b>10:50 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>214 N. Potomac St., Hagerstown, Md.</b>	
ACTUAL SIGNATURE <b>Lloyd A. Hoffmann</b>		DATE SIGNED <b>Sept 5, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffmann</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/7/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Fairview Cemetery</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		22d. LOCATION (City, town, or county) (State) <b>Keedysville Wash. Co Md.</b>	
ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Sept 9, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Frank H. Bowers</b>

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09920

9952

## CERTIFICATE OF DEATH

Reg. Dist. No.

301

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				d. STREET ADDRESS 38 West Salisbury Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lydia		First	Middle	Last	4. DATE OF DEATH September 23 1957	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1873	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS. Days 23	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Pinesburg, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Isaac Grove				14. MOTHER'S MAIDEN NAME Sophia Cook				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT 317-80-5367 Mrs. Ruth Cottrill		Address Williamsport, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO		Colorectal Cancer		INTERVAL BETWEEN ONSET AND DEATH Today		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Williamsport		(County) (State)
21. I certify that I attended the deceased from alive on		9/23/57		9/23/57		that I last saw the deceased ADDRESS (Street, city, or town, state) Williamsport, Md.		DATE SIGNED 9/23/57
ACTUAL SIGNATURE Howard F. Young								
PHYSICIAN'S NAME (Type) Burial		22b. DATE THEREOF 9/26/57		22c. NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery		22d. LOCATION (City, town, or county) Williamsport		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard F. Young		ADDRESS Hancock mol		24a. REC'D BY REGISTRAR DATE Sept. 26-57		24b. REGISTRAR'S SIGNATURE Lee McElroy		

## CERTIFICATE OF DEATH

RECEIVED  
FBI - BUREAU OF INVESTIGATION

SEP 30 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 9921 CERTIFICATE OF DEATH 09921  
 Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>16 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>320 W. HOWARD ST.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN RICHARD CRIM</b>		d. STREET ADDRESS <b>320 W. HOWARD ST.</b>	
4. DATE OF DEATH <b>SEPT. 18 1957</b>	Month Year	5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>3/25/1883</b>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>74 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during time of working life, even if retired) <b>RETIRED BOOKKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER CO. OFFICE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RUFUS SMITH CRIM</b>		14. MOTHER'S MAIDEN NAME <b>SARAH C. MULL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>180-10-3093</b>	
17. INFORMANT <b>MISS IDA L. CRIM</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <i>Cor Pulmonare</i>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo yrs</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>026X</b> DUE TO <i>Arterio Spasm, Texas</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Coron. Stenosis</i>		6 yrs	
(c) DUE TO <i>Cerebro-Spinal Tics</i>		30 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 1, 1953, to 9-18 1957</b> that I last saw the deceased alive on <b>9-17 1957</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert P. Conrad</i>	PHYSICIAN'S NAME (Type) <i>Robert P. Conrad</i>	ADDRESS (Street, city or town, state) <b>137 W. Washington</b>	DATE SIGNED <b>9-18-57</b>
22a. BURIAL, CREMATION, OR OTHER (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9/20/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>BAKERSVILLE CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>WASHINGTON COUNTY MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Horment, Hagerstown, Md.</i>		ADDRESS <b>Sept. 21, 1957</b>	24a. EG'D. BY REGISTRAR <b>W. J. Horment</b>
			24b. REGISTRAR'S SIGNATURE <i>W. J. Horment</i>

## CERTIFICATE OF DEATH

NAME

ADDRESS

DEATH

TO

NAME

ADDRESS

TO

NAME

ADDRESS

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SEP 24 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page could be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9922 CERTIFICATE OF DEATH 09922  
 Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>5 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>RACHEL</b>		First <b>SUSAN</b>	Middle <b>DALEY</b>		
4. DATE OF DEATH <b>SEPT. 22 19 57</b>	Month <b>SEPT.</b>	Day <b>22</b>	Year <b>19 57</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/9/1880</b>		
9. AGE (In years last birthday) <b>77 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		
13. FATHER'S NAME <b>JACOB MYERS</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET BOWARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MR. ANGLE M. DALEY</b>		
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diseases, Malaria, Arterio sclerosis,</b> INTERVAL BETWEEN ONSET AND DEATH year year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month <b>Aug</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>RT. #4 HAGERSTOWN MD.</b>	(County) <b>Hagerstown</b>	(State) <b>MD.</b>
21. I certify that I attended the deceased from <b>22 Aug 1957</b> to <b>22 Sept 1957</b> that I last saw the deceased alive on <b>22 Aug 1957</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Elderly Woodlock</b>	M.D.		ADDRESS (Street, city or town, state) <b>Hagerstown MD</b>		
PHYSICIAN'S NAME (Type) <b>E. Woodlock M.D.</b>	DATE SIGNED <b>9/27/57</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9/24/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>PLEASANT HILL U.B. CHURCH</b>	22d. LOCATION (City, town, or county) (State) <b>FRANKLIN CO. PENNA.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. T. Neumann, Hagerstown, Md.</b>		ADDRESS <b>81</b>	24a. REC'D BY REGISTRAR <b>Sept. 27, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>John H. Powers</b>	

## BUREAU V. 2

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

0992302  
 Reg. Dist. No.

9923

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE Maryland b. COUNTY Washington	
Hagerstown		7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Hagerstown		d. STREET ADDRESS	
Washington County Hospital		03		1 2417 Penna Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					

3. NAME OF DECEASED (Type or print)	First George	Middle --	Last Davis	4. DATE OF DEATH	Month Sept. 20, 1957	Day 19	Year
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 21, 1891	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	Year
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman W.M.R.R.	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Yugo slavia	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME No record	14. MOTHER'S MAIDEN NAME No record	Address Mrs. Blanche Hawbaker- 521 E. Antietam St Hagerstown Md.
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No	16. SOCIAL SECURITY NO. ---	17. INFORMANT Fractured Skull	INTERVAL BETWEEN ONSET AND DEATH 7 days
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull</b>	
812X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian that was hit by automobile		
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20c. TIME OF INJURY Hour 4:45 p. m. Sept. 14, 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) Hagerstown	(County) Wash	(State) Md.
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21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>S. Robert Wells</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 9-21-57
EXAMINER'S NAME (Type) S. Robert Wells, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-22-57	22c. NAME OF CEMETERY OR CREMATORIUM Smithsburg Cemetery	22d. LOCATION (City, town, or county) (State) Smithsburg, Wash Co Md
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23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman	ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR 1957	24b. REGISTRAR'S SIGNATURE <i>Beth Bessell</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEDDING EXHIBIT CERTIFICATE OF DESIGN  
THE STATE OF PENNSYLVANIA - BUREAU OF EVIDENCE

BUREAU V. 8

SEP 25 1957

BUREAU V. 8  
REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09924

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport R # 1</b>		c. LENGTH OF STAY IN 1b <b>68 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/ Williamsport R # 1</b>		d. STREET ADDRESS <b>near Downsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>near Downsville</b>				d. STREET ADDRESS <b>near Downsville</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>SUSAN</b>		First <b>SUSAN</b> Middle <b>SALLY</b>		Lost <b>DELLINGER</b>		4. DATE OF DEATH <b>Sept 24 1957</b>	Month <b>19</b>	Day <b>24</b>	Year <b>1957</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Aug 15 1884</b>	9. AGE (In years last birthday) <b>73</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Wash. Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William H. Dellinger</b>				14. MOTHER'S MAIDEN NAME <b>Mary Slifer</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Ruth Dellinger</b>		Address <b>Williamsport R # 1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Generalized arteriosclerosis</b>				<i>Secondary genic Carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>							
20c. TIME OF INJURY Hour <b>o. m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) <b>None</b> (State) <b>None</b>			
21. I certify that I attended the deceased from <b>May 15</b> , 1957, to <b>Sept 24</b> , 1957, that I last saw the deceased alive on <b>Sept 23</b> , 1957, and that death occurred at <b>1403</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward W. Ditto</i>				ADDRESS (Street, city or town, state) <b>217 W. Washington St. Hagerstown, Md.</b>		DATE SIGNED <b>9/25/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/26/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>River View Cemetery</b>		22d. LOCATION (City, town, or county) <b>Williamsport Wash. Co Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		ADDRESS <b>None</b>		24a. REC'D BY REGISTRAR <b>Sept 26/57</b>		24b. REGISTRAR'S SIGNATURE <b>E. S. McElroy</b>			

## CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	8010	8011	8012	8013	8014	8015	8016	8017	8018	8019	8020	8021	8022	8023	8024	8025	8026	8027	8028	8029	8030	8031	8032	8033	8034	8035	8036	8037	8038	8039	8040	8041	8042	8043	8044	8045	8046	8047	8048	8049	8050	8051	8052	8053	8054	8055	8056	8057	8058	8059	8060	8061	8062	8063	8064	8065	8066	8067	8068	8069	8070	8071	8072	8073	8074	8075	8076	8077	8078	8079	8080	8081	8082	8083	8084	8085	8086	8087	8088	8089	8090	8091	8092	8093	8094	8095	8096	8097	8098	8099	80100	80101	80102	80103	80104	80105	80106	80107	80108	80109	80110	80111	80112	80113	80114	80115	80116	80117	80118	80119	80120	80121	80122	80123	80124	80125	80126	80127	80128	80129	80130	80131	80132	80133	80134	80135	80136	80137	80138	80139	80140	80141	80142	80143	80144	80145	80146	80147	80148	80149	80150	80151	80152	80153	80154	80155	80156	80157	80158	80159	80160	80161	80162	80163	80164	80165	80166	80167	80168	80169	80170	80171	80172	80173	80174	80175	80176	80177	80178	80179	80180	80181	80182	80183	80184	80185	80186	80187	80188	80189	80190	80191	80192	80193	80194	80195	80196	80197	80198	80199	80200	80201	80202	80203	80204	80205	80206	80207	80208	80209	80210	80211	80212	80213	80214	80215	80216	80217	80218	80219	80220	80221	80222	80223	80224	80225	80226	80227	80228	80229	80230	80231	80232	80233	80234	80235	80236	80237	80238	80239	80240	80241	80242	80243	80244	80245	80246	80247	80248	80249	80250	80251	80252	80253	80254	80255	80256	80257	80258	80259	80260	80261	80262	80263	80264	80265	80266	80267	80268	80269	80270	80271	80272	80273	80274	80275	80276	80277	80278	80279	80280	80281	80282	80283	80284	80285	80286	80287	80288	80289	80290	80291	80292	80293	80294	80295	80296	80297	80298	80299	80300	80301	80302	80303	80304	80305	80306	80307	80308	80309	80310	80311	80312	80313	80314	80315	80316	80317	80318	80319	80320	80321	80322	80323	80324	80325	80326	80327	80328	80329	80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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9954

## CERTIFICATE OF DEATH

09925  
Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MAPLEVILLE</b>		c. LENGTH OF STAY IN 1b <b>11 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 MAPLEVILLE</b>		d. STREET ADDRESS <b>BOONSBORO MD. ROUTE 2</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BOONSBORO MD. ROUTE 2</b>				d. STREET ADDRESS <b>BOONSBORO MD. ROUTE 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>LAURA</b>		First	Middle	Lost	4. DATE OF DEATH <b>DETROW</b>	Month	Day	Year		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 5 1883</b>	9. AGE (In years last birthday) <b>74</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MT. AETNA WASH. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>JOHN HUBERT DETROW</b>		14. MOTHER'S MAIDEN NAME <b>MARTON FOLTZ</b>		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. ROSCOE MILLER BOONSBORO ED. R. 2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emboli</b> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Heart Disease</b> (c) <b>Arterio Sclerosis Generalized</b>			19. INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from <b>Aug 9</b> , 1957, to <b>Sept 2</b> , 1957, that I last saw the deceased alive on <b>Sept 2</b> , 1957, and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>G. A. Kohler</b> PHYSICIAN'S NAME (Type) <b>G. A. KOHLER</b>		ADDRESS (Street, city or town, state) <b>Plantersburg Md</b>		DATE SIGNED <b>9/3/57</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>SEPT. 5 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>BEAVER CREEK CEMETERY BEAVER CREEK WASH. CO. MD.</b>		22d. LOCATION (City, town, or county) (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bald Jewel Home Boonsboro Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>Sep. 5 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Bald</b>				

BUREAU V. 5

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9924

09926

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BX

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>3 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 1</b>		d. STREET ADDRESS <b>Mt Etna</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Nursing Home</b>				d. STREET ADDRESS <b>Mt Etna</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JESSIE</b>		First <b>EDITH</b>	Middle <b>ENGLISH</b>	Lost	4. DATE OF DEATH <b>Sept 9 1957</b>	Month <b>19</b>	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4 1870</b>	9. AGE (In years lost birthday) <b>87 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Lovettsville Loudon Co USA</b>			
13. FATHER'S NAME <b>George W. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Mary Fry</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Lillian Wolf 525 Frederick St</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease.</b> INTERVAL BETWEEN ONSET AND DEATH Years. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy.	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from <b>May 1, 1957</b> to <b>Sept. 9, 1957</b> that I last saw the deceased alive on <b>Sept. 2, 1957</b> , and that death occurred at <b>1:00A M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac St.</b> DATE SIGNED <b>9-10-57</b>									
ACTUAL SIGNATURE <i>R. A. Bell</i>		PHYSICIAN'S NAME (Type) <b>R. A. Bell, M. D.</b> Hagerstown, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/11/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Funkstown Cemetery</b>		22d. LOCATION (City, town, or county) <b>Funkstown Wash. go Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		ADDRESS		24a. REC'D. BY REGISTRAR <b>Sept. 12, 1957 by H. A. Bowers</b>	24b. REGISTRAR'S SIGNATURE				

## BUREAU V. S.

SEP 13 1957

## РЕГЕИВЕД

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9955

## CERTIFICATE OF DEATH

09927  
306

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Penmar		c. LENGTH OF STAY IN 1b 10 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Galesville	
3. NAME OF DECEASED (Type or print)		First William	Middle Thomas
4. DATE OF DEATH		Month Sept.	Day 16
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan. 2, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Retired		Oyster Co.	Woodfield Fish and Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Fifer Sr.		Mary Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		5	Mrs. William Thomas Fifer Jr., Galesville Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		15 Minutes	
420.1 DUE TO Coronary Occlusion			
Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause lost.		(b)	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 16 Sept. 1957, to 16 Sept. 1957, that I last saw the deceased alive on 16 Sept. 1957, and that death occurred at 7:30 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Robert A. Fluehr		DATE SIGNED 16 Sept. 1957	
PHYSICIAN'S NAME (Type)		M.D. Blue Ridge Lumber Co., Pa.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/19/57	22c. NAME OF CEMETERY OR CREMATORIAL Quaker Burying Ground
22d. LOCATION (City, town, or county) Galesville		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Galloway, Waynesboro Pa.		24a. REGD. BY REGISTRAR SEP 20 1957	24b. REGISTRAR'S SIGNATURE A. L. French
		DATE	

## CERTIFICATE OF DEATH

RECEIVED  
BUREAU V. S.

SEP 20 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09928  
 9925 CERTIFICATE OF DEATH Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charmian 75x-3	
3. NAME OF DECEASED (Type or print) First MIDDLE Last SANDRA KAY FITZ		4. DATE OF DEATH Month Sept. Day 7, Year 1957	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 28, 1948	
9. AGE (In years lost birthday) 8 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Waynesboro Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ray C. Fitz		14. MOTHER'S MAIDEN NAME Betty J. Bowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
		Ray C. Fitz Charmian Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral edema</i> DUE TO <i>237X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Brain tumor</i> DUE TO <i>Seven years</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Seven weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>No</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8-30</i> , 19 <i>57</i> , to <i>9-7</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>9-6</i> , 19 <i>57</i> , and that death occurred at <i>6:45 A</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>E. Margaret Sullivan, M.D.</i> DATE SIGNED <i>314 N. Potomac St.</i> <i>Hagerstown, Maryland</i>	
ACTUAL SIGNATURE <i>E. Margaret Sullivan</i>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/9/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Fountaindale</i>		22d. LOCATION (City, town, or county) (State) <i>Fairfield, Adams Pa., R.F.D. 1</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter J. Gove, Waynesboro Pa.</i>		ADDRESS <i>819.1957</i>	
		24a. RECD. BY REGISTRAR <i>Shirley Baxters</i>	
		24b. REGISTRAR'S SIGNATURE	

## CERTIFICATE OF DEATH

FBI  
BUREAU V. S.

SEP 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9926

## CERTIFICATE OF DEATH

09929

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>70 years</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>515 Reynolds Ave.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Edna</b>	Middle <b>Giegas</b>			
4. DATE OF DEATH <b>Sept. 12 1957</b>		Month <b>Sept.</b>	Day Year <b>12 1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1886</b>			
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>			
13. FATHER'S NAME <b>Aaron Lawrence</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Cross</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	17. INFORMANT <b>Edward C. Giegas</b>			
			Address <b>Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>119 N. Potomac St.</b>	20f. (City or town) <b>Hagerstown</b>	(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>April 12, 1956</b> , to <b>Sept. 12, 1957</b> , that I last saw the deceased alive on <b>Sept. 12, 1957</b> , and that death occurred at <b>1:10 A</b> , from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>R. A. Bell</i>		ADDRESS (Street, city or town, state) <b>119 N. Potomac St. Hagerstown Md.</b>		DATE SIGNED <b>September 13, 1957.</b>		
PHYSICIAN'S NAME (Type) <b>R. R. A. Bell</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				
22b. DATE THEREOF <b>9-14-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Sept. 17, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Phast Powers</b>	

WISCONSIN STATE DEPARTMENT OF HEALTH - BURLINONE, WI  
CERTIFICATE OF DEATH

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RECEIVED  
BUREAU Y. &  
SEP 19 1957  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9927

## CERTIFICATE OF DEATH

09930

Reg. Dist. No.

302

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <i>Mercersburg Pa.</i>		COUNTY <i>Franklin</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN 1b <i>2 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mercersburg Pa.</i>		d. STREET ADDRESS <i>15 x 5</i>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hagerstown Hospital</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>Uria</i>		First <i>Uria</i>	Middle <i>A</i>	Last <i>Guss</i>	4. DATE OF DEATH <i>Sept. 13 1957</i>	Month <i>Sept.</i>	Day <i>13</i>	Year <i>1957</i>							
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 30 1880</i>	9. AGE (In years lost birthday) <i>76 yrs.</i>	10. IF UNDER 1 YEAR Months <i>11</i>	11. IF UNDER 24 HRS. Days <i>13</i>	Hours <i>0</i>	Min. <i>0</i>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Minister</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Mifflin, Franklin County</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>									
13. FATHER'S NAME <i>William Guss</i>		14. MOTHER'S/MAIDEN NAME <i>Mary Ann Moyer</i>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs. Editha Thomas, Mercersburg Pa.</i>		Address									
18. CAUSE OF DEATH [Enter only one cause per line to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177x</i>		DUE TO <i>Coronary Thrombosis &amp; Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i>		DUE TO <i>—</i>													
DUE TO <i>(c)</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Coronary Thrombosis &amp; Myocardial Infarction</i>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>—</i>		20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i>—</i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County) <i>—</i>		(State) <i>—</i>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A.M., from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <i>—</i>		DATE SIGNED <i>Sept. 13 1957</i>				
ACTUAL SIGNATURE <i>W.C. BREWER</i>		M.D. <i>—</i>													
PHYSICIAN'S NAME (Type) <i>W.C. BREWER</i>															
22a. BURIAL, CREMATION, REMOVAL—(Specify) <i>9-15-57</i>		22b. DATE THEREOF <i>9-15-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Burview</i>		22d. LOCATION (City, town, or county) <i>Mercersburg, Pa.</i>		(State) <i>—</i>							
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.H. Brumley, Mercersburg, Pa.</i>		ADDRESS <i>18. 1957, B. H. Bowers</i>		24a. REC'D BY REGISTRAR <i>Sept. 18, 1957, B. H. Bowers</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>									

CERTIFICATE OF DEATH

Male  
White

BUREAU V. S.

SEP 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
Item 7 FilmG220 9-13-57 et  
**CERTIFICATE OF DEATH**

09931  
302  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>18 Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>		d. STREET ADDRESS <b>634 George St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>HENRY</b>		First <b>BLESSING</b>	Middle <b>HARTFORD</b>	4. DATE OF DEATH <b>Sept 1 1957</b>	Month Day Year 19				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14 1894</b>	9. AGE (In years lost birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pangborn Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Henry E. Hartford</b>		14. MOTHER'S MAIDEN NAME <b>Lillie M. Shoppert</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.# 1</b>		17. INFORMANT <b>Claude S. Hartford</b> <i>Chambersburg Pa</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>My condition</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Years.</b>					
(b) DUE TO <b>Emergency</b>									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Hagerstown Wash Co Md.</b>	(County) <b>Hagerstown</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>10-21</b> , 19 <b>57</b> , to <b>1 Oct</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1 Oct</b> , 19 <b>57</b> , and that death occurred at <b>6-24</b> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>115 W. Washington</b>	DATE SIGNED <b>9/21/57</b>		
ACTUAL SIGNATURE <b>Eldon S. Hoachland</b>									
PHYSICIAN'S NAME (Type) <b>Eldon S. Hoachland</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/5/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Wose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Wash Co Md.</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		ADDRESS		24a. REC'D. BY REGISTRAR <b>Sept 6, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Shast H. Bowers</b>			

BUREAU V. 21

750 9 5

REGELIV ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Postage and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9929

## CERTIFICATE OF DEATH

09932

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Frederick</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>47 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Myersville</b>		d. STREET ADDRESS <b>Rt. #7 Spruce Run Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>DAVID</b>	Middle <b>EDWARD</b>	Last <b>HIMES</b>	4. DATE OF DEATH <b>September 16 1957</b>	Month <b>September</b>	Day <b>16</b>	Year <b>1957</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>March 23, 1883</b>	9. AGE (In years lost birthday) <b>74</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William Himes</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Stottlemeyer</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-14-6981</b>		17. INFORMANT <b>Mrs. Bertha Finneyfrock, Myersville, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>157X</b>		Carcinoma of the Pancreas with generalized metastasis. INTERVAL BETWEEN ONSET AND DEATH <b>4 mo.</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>7/19</b> , 1955, to <b>9/16</b> , 1957, that I last saw the deceased alive on <b>9/16</b> , 1957, and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Charles F. Hess</b>		ADDRESS (Street, city or town, state) <b>Smithsburg, Md.</b> DATE SIGNED <b>9/18/57</b>						
PHYSICIAN'S NAME (Type) <b>Charles F. Hess</b>		Smithsburg, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-19-1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Grosskickles</b>		22d. LOCATION (City, town, or county) <b>Nr. Myersville, Fred. Co. Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>		ADDRESS <b>Myersville, Md.</b> 24a. RECD. BY REGISTRAR DATE <b>Sept. 20, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Charles Bowers</b>						

BUREAU V. 8

SEP 23 1957

REGELY ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9930

## CERTIFICATE OF DEATH

09933

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 mo. 11 day				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md RFD 1 X/				
3. NAME OF DECEASED (Type or print)	First John	Middle Frederick	Last Hornbaker			
4. DATE OF DEATH	Month Sept.	Day 8	Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 21 1940			
9. AGE (In years lost birthday) 17 yrs.		10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS. Days 17			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Public School	11. BIRTHPLACE (State or foreign country) Marlowe W. Va.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ralph Jacob Hornbaker				
14. MOTHER'S MAIDEN NAME Mary Margaret Boppe		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Ralph J. Hornbaker				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Address Falling Waters Rd Williamsport Md RFD 1 INTERVAL BETWEEN ONSET AND DEATH 2 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Williamsport	(County)	(State)
21. I certify that I attended the deceased from <u>June</u> , 1955, to <u>8 Sept</u> , 1957, that I last saw the deceased alive on <u>8 Sept</u> , 1957, and that death occurred at <u>340 P.M.</u> from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Paul Hattie</i>	M.D.		ADDRESS (Street, city or town, state) 28 W. Potomac Street		DATE SIGNED 9 Sept 57.	
PHYSICIAN'S NAME (Type) PAUL HATTIE		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Maryland		
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 10-57		24a. RECEIVED BY REGISTRAR DATE Sept. 10, 1957		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert X. of Williamsport, Md</i>		ADDRESS		24b. REGISTRAR'S SIGNATURE <i>John H. Cross</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be delivered for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

REG. NO. 11

BUREAU V. 4  
RECEIVED

SEP 13 1957

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09935

9931

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 48 years		b. COUNTY		Wash.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 49 Fairgraound Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 49 Fairground Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Alice	Middle Madeline	Last Long	4. DATE OF DEATH	Month Sept. 16	Day 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1908		9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) presser		10b. KIND OF BUSINESS OR INDUSTRY laundry		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William C. Oden		14. MOTHER'S MAIDEN NAME Anna Barnhart					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-12-1341		17. INFORMANT Raymond E. LeFevre, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		420.1		Serene Arterio-Sclerotic Hypertension		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b)		Cardio-Vascular Disease with terminal (c) Coronary Occlusion		5 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D. 230 N. Potomac St.	(County) (State)
21. I certify that I attended the deceased from		1951 to 16 Sept 1957		that I last saw the deceased alive on		1957, and that death occurred at 4:45 PM, from the causes and on the date stated above.	
ACTUAL SIGNATURE Physician's NAME (Type)		Frank F. Lusby, M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED 17 Sept 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-19-57		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR 1957		24b. REGISTRAR'S SIGNATURE B. H. Bowers	

## BUREAU V. 2

SEP 23 1957

RECEIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09936

Items 8 & 9, Film G221, 10/3/57 for  
9932 Item 7 Film G221 10-3-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 18 days		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS 54 W. Franklin St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harvey	Middle F	Last Mellinger
4. DATE OF DEATH	Month 9	Day 23	Year 19 57
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 8 Apr. 7, 1885
9. AGE (In years last birthday) 70 6 9 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY General	
10c. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 17. INFORMANT 1905-1912 219-20-0096 Mrs. Ruth Monninger Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Hodgkins Disease INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1957, to 23 Sept, 1957, that I last saw the deceased alive on 23 Sept, 1957, and that death occurred at 7 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 78 W. Potomac St., Williamsport, Md.	
ACTUAL SIGNATURE PAUL HRAIC, M.D.		DATE SIGNED 25 Sept 57	
PHYSICIAN'S NAME (Type)		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial 9-27-57		22f. NAME OF CEMETERY OR CREMATORIAL Rose Hill	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE Sept. 26 1957	
		24b. REGISTRAR'S SIGNATURE Fred H. Boevers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09937

Reg. Dist. No.

302

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, or removal.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Sharpsburg</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Leitersburg</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Taylor's Landing</b>				d. STREET ADDRESS <b>R # 5 Hagerstown</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <b>Edwin Wendell Miller</b>		First <b>Edwin</b>	Middle <b>Wendell</b>	Last <b>Miller</b>	4. DATE OF DEATH <b>Sept. 1</b>	Month <b>Sept.</b>	Day <b>1</b>	Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 12, 1906</b>		9. AGE (In years last birthday) <b>51 yrs.</b>		IF UNDER 1YEAR Months <b>6</b> Days <b>19</b> Hours <b>00</b> Min. <b>00</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wendell Miller</b>				14. MOTHER'S MAIDEN NAME <b>Edna Conrad</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W. W. #1</b>		17. INFORMANT <b>Richard Miller - Hagerstown, Maryland</b>		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to drowning</b>										
850X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)										
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drowned when lost balance and fell out of fishing boat</b>								
20c. TIME OF INJURY Hour <b>5:30</b> a.m. <b>Sept. 1<sup>st</sup> 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>River</b>		20f. (City or town) <b>Rural Sharpsburg</b>		(County) (State) <b>Wash Md</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							DATE SIGNED <b>9-3-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-4-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>			22d. LOCATION (City, town, or county) <b>Hagerstown, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>									ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>9-4-57</b>									24b. REGISTRAR'S SIGNATURE <i>E. G. Boyer</i>	

87. ВОЛГА-БАЛТИЙСКАЯ РЕГИОНАЛЬНАЯ СЕТИ СТАНЦИЙ ОБСЛЕДОВАНИЯ И РЕГИОНАЛЬНЫХ ЦЕНТРОВ ПОДДЕРЖАНИЯ ЗДОРОВЬЯ.

RECEIVED SEP 13 1957 BUREAU V. E.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09938

Reg. Dist. No. *302*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains or prior to burial, cremation, or removal.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>		d. STREET ADDRESS <b>111 Bloom Alley</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>111 Bloom Alley</b>										
<b>3. NAME OF DECEASED</b> (Type or print) <b>Lucius</b>		First <b>Lucius</b>	Middle <b>(ne)</b>	Last <b>Moen</b>	<b>4. DATE OF DEATH</b>	Month <b>Sept</b>	Day <b>4</b>	Year <b>1957</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Celored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 4 1889</b>		9. AGE (In years last birthday) <b>68 yrs.</b>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public builning</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Unknow</b>			14. MOTHER'S MAIDEN NAME <b>Unknow</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>214-09-0576</b>		17. INFORMANT <b>Irene Moen</b> Address <b>408 Suman Ave.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <p align="center"><b>Part I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Perforated peptic ulcer with acute peritonitis</b></p> <p align="center"><b>540.1</b></p> <p align="center">DUE TO</p> <p align="center">Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. <b>(b)</b></p> <p align="center">DUE TO</p> <p align="center">(c)</p> <p align="center"><b>Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b></p> <p align="center"><b>None</b></p>									INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> p. m. <b>none</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) <b>-</b> (County) <b>-</b> (State) <b>-</b>				
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <b>S. Robert Wells</b>									DATE SIGNED <b>9-6-57</b>	
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-7-1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>			22d. LOCATION (City, town, or county) <b>Hagerstown Maryland</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr. Hagerstown Md</b>									24a. REC'D. BY REGISTRAR <b>Sept. 9, 1957</b> DATE	
									24b. REGISTRAR'S SIGNATURE <b>Robert Bowers</b>	

RECEIVED - DEPARTMENT OF DEFENSE  
U. S. GOVERNMENT - CALIFORNIA STATE DEPARTMENT OF DEFENSE

RECEIVED V. S.

SEP 11 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9934

## CERTIFICATE OF DEATH

09939

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural - Sharpsburg	
3. NAME OF DECEASED (Type or print) Annie		First May	Middle Lost Myers
4. DATE OF DEATH September 27		Month Year 57 19	Day Year 27 19
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 10, 1884		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Marshall	
14. MOTHER'S MAIDEN NAME Cornelia Himes		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 202-18-2884		17. INFORMANT John Edw. Myers Address RFD# 2, Sharpsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 month Congestive heart failure	
(b) DUE TO Coronary occlusion and infarct		5½ months	
(c) DUE TO Hypertensive, arteriosclerotic C. V. disease		5 Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral hydrothorax.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/12/57, 19, to 9/27/57, 19, that I last saw the deceased alive on 9/26/57, 19, and that death occurred at 5:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Walter H. Shealy M.D. Sharpsburg, Md. 9/27/57			
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 9/30/57		22c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE F. Donald Ackles		24a. REC'D BY REGISTRAR Oct. 1, 1957	
ADDRESS Harpers Ferry West Va.		24b. REGISTRAR'S SIGNATURE B. H. Powers	

CERTIFICATE OF DEATH

BUREAU V. S

OCT 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9935 CERTIFICATE OF DEATH**

09940  
 Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4½ years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b>		b. COUNTY <b>Franklin</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Homewood Church Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mercersburg</b>		f. STREET ADDRESS <b>302 S. Park Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GRACE</b>	First <b>V.</b>	Middle <b>Y.</b>	Lost <b>MYERS</b>	4. DATE OF DEATH <b>September 20 1957</b>	Month <b>September</b>	Day <b>20</b>	Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>October 3, 1882</b>	9. AGE (In years low birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR <b>11 months</b>	IF UNDER 24 HRS. <b>17 days</b>	Hours <b>0 hours</b>	Min. <b>0 minutes</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Mercersburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James R. Myers</b>				14. MOTHER'S MAIDEN NAME <b>Alice M. Keefer</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Rev. Mark Wagner</b>		Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6-1-57</b> , 19 <b>57</b> , to <b>7-20</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9-10-57</b> , 19 <b>57</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>J. S. C. Oct 1957</b>		M.D.		ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b>		DATE SIGNED <b>9/3/57</b>			
PHYSICIAN'S NAME (Type) <b>J. S. C. Oct 1957</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/23/1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mercersburg, Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Sept. 23, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Powers</b>			
VS A15 (4) 15M 9/55									



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9936

## CERTIFICATE OF DEATH

09941  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>8 Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>		d. STREET ADDRESS <b>210 Frederick St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>RUSSELL</b>		First <b>LEE</b>	Middle <b>PENTZ</b>	Last <b>PENTZ</b>	4. DATE OF DEATH <b>Sept 30 1957</b>	Month <b>Sept</b>	Day <b>30</b>	Year <b>1957</b>					
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 19 1896</b>	9. AGE (In years last birthday) <b>60</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paper Hanger</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE <b>Cumberland Co Mechanicsburg Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Russell I. Pentz</b>		14. MOTHER'S MAIDEN NAME <b>Camilla R. Schultz</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-05-4390</b>							
17. INFORMANT <b>Russell Jack Pentz Maugansville Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with angina</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>2 yr.</b>									
DUE TO <b>420.0</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (b) <b>Hypertensive cardiovascular disease</b>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
DUE TO <b>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</b>		DUE TO <b>(c)</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>148 West Washington Street</b>		(County) <b>Hagerstown</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from alive on <b>Sept. 29</b> , 1957, and that death occurred at <b>12:40A</b> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)						DATE SIGNED <b>9/30/57</b>			
ACTUAL SIGNATURE <i>B. B. Kneisley</i>		PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M. D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/2/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Oct. 3, 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Frank Gowers</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BUREAU V.

1957 7 OCT

REGELY ED

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09942

Reg. Dist. No. 302

9937

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		d. STREET ADDRESS <b>1109 Virginia Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>Robert</b>	Last <b>Potts, Sr.</b>	4. DATE OF DEATH	Month <b>September</b>	Day <b>15</b>	Year <b>19 57</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 1, 1912</b>	9. AGE (In years last birthday) <b>44 yrs.</b>	IF UNDER 1 YEAR <b>10</b>	IF UNDER 24 HRS. <b>11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocerman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own business</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry W. Potts</b>				14. MOTHER'S MAIDEN NAME <b>Grace Summers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <b>218-30-9143</b>		17. INFORMANT <b>Mrs. Hester M. Potts</b>	Address <b>Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic coronary heart disease</b>							
DUE TO <b>420.1</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
none							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year <b>none 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) <b>—</b>	(County) <b>—</b>	(State) <b>—</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <b>S. Robert Wells</b>		DATE SIGNED <b>9-16-57</b>					
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/18/1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		ADDRESS <b>R. Franklin Rouser</b>		24a. REC'D BY REGISTRAR <b>Sept. 18, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Sowers</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEDGWOOD EXAMINER'S CERTIFICATE OF FRESH  
WATER TO THE STATE OF MICHIGAN - BALTIMORE 19

305

WATER

BUREAU U. S.

SEP 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9957

## CERTIFICATE OF DEATH

09943

Reg. Dist. No. 300

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SHARPSBURG</b>		c. LENGTH OF STAY IN 1b <b>35 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 SHARPSBURG</b>		d. STREET ADDRESS <b>120 ANTETAM ST.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>120 ANTETAM ST.</b>				d. STREET ADDRESS <b>120 ANTETAM ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>IRENE</b>		First <b>C</b>	Middle <b>PRY</b>	Lost	4. DATE OF DEATH <b>SEPT. 11 1957</b>	Month <b>Sept</b>	Day <b>11</b>	Year <b>19</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 10 1864</b>	9. AGE (In years last birthday) <b>93</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>KEEDYSVILLE WASH.CO.MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>ALFRED COST</b>				14. MOTHER'S MAIDEN NAME <b>MARY BOVEY</b>		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MISS NAOMI NUNAMAKER SHARPSBURG MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause last. <b>(b)</b> DUE TO <b>(c)</b>		Generalized arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Boonsboro</b>	(County) <b>Washington</b>	(State) <b>MD.</b>		
21. I certify that I attended the deceased from <b>Sept 11</b> , 1957, to <b>Sept 11</b> , 1957, that I last saw the deceased alive on <b>Sept 11</b> , 1957, and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>G. W. LeVan</b>				ADDRESS (Street, city or town, state) <b>Boonsboro</b>		DATE SIGNED <b>6/13/57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>SEPT. 14 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>FAIRVIEW CEMETERY</b>	22d. LOCATION (City, town, or county) <b>KEEDYSVILLE WASH.CO.MD.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bast Funeral Home Boonsboro Md.</b>		ADDRESS <b>Boonsboro</b>		24a. REC'D BY REGISTRAR <b>Sept. 17, 57</b>	24b. REGISTRAR'S SIGNATURE <b>E. G. Boyer</b>			

СЕВЕРОДВИНСК—ИТАЛІЯ 30 ТРЕТЬЯ РІЧАСТЬ ОНАДІЯ

**BUREAU V. S.**

SEP 19 1957

REGELY ED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09944

Reg. Dist. No. 302

9958

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b> <i>x2</i>			
3. NAME OF DECEASED (Type or print)		First <b>CHARLES</b>	Middle <b>WILLIAM</b>	Last <b>RANKIN</b>	4. DATE OF DEATH <b>SEPT. 28 1957</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/2/1887</b>		9. AGE (in years last birthday) <b>70 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>SAND CO.</b>			11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
13. FATHER'S NAME <b>JOSEPH RANKIN</b>				14. MOTHER'S MAIDEN NAME <b>MARY SHERLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yours or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W. #1</b>		17. INFORMANT <b>MRS. SUVINA RANKIN</b> <i>RT. #2</i>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushing injury of chest</b> INTERVAL BETWEEN ONSET AND DEATH <i>825X</i>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Subcutaneous and mediastinal emphysema</b> 12 hours							
DUE TO (c) <b>Cardiac contusion</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 19. WAS AUTOPSY CAUSE OF DEATH. PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was in auto accident</b>							
20c. TIME OF INJURY Month, Day, Year Hour <b>11:55 p.m. Sept. 27, 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40 West Hagerstown, Washington, Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Dr. E. W. Ditto</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>Sept. 30, 1957</b>							
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>10/1/1957</b> 22c. NAME OF CEMETERY OR CREMATORIUM <b>BETHEL CEM.</b> 22d. LOCATION (City, town, or county) <b>MORGAN CO.</b> (State) <b>W. VA.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. J. Norment, Hagerstown, Md.</i>				24a. REC'D. BY REGISTRAR <i>Oct. 1, 1957</i> 24b. REGISTRAR'S SIGNATURE <i>Charles H. Bowers</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEDGWOOD EXHIBITION CERTIFICATE OF GSAH

BUREAU V. S.

OCT 4 1957

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9938

## CERTIFICATE OF DEATH

09945

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town HAGERSTOWN, MD.		c. LENGTH OF STAY IN 1b 2 DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First MELCHORA	Middle MAE	Last RENNER	
4. DATE OF DEATH	Month SEPT.	Day 7	Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH NOV. 30, 1896	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME DUTIES		10b. KIND OF BUSINESS OR INDUSTRY NONE		
11. BIRTHPLACE (State or foreign country) ST. PAULS, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH MELCHOR HARSH		14. MOTHER'S MAIDEN NAME SUSAN MYERS		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-34-1190 17. INFORMANT MRS HAZEL GROVE		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		136 FAIRGROUND AVE HAGERSTOWN, MD. Address INTERVAL BETWEEN ONSET AND DEATH 4 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cholelithiasis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour o. s. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Box 166 (County) (State)	
21. I certify that I attended the deceased from <u>Sept 5, 1957</u> , to <u>Sept 7, 1957</u> , that I last saw the deceased alive on <u>Sept 6, 1957</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>David R. Brewer</u> M.D. DATE SIGNED <u>9/7/57</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 10, 1957	22c. NAME OF CEMETERY OR CREMATORIAL ST. PAULS CEM.	22d. LOCATION (City, town, or county) WASH. CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>		ADDRESS CLEAR SPRING, MD.	24a. RECD BY REGISTRAR DATE Sept. 11, 1957	24b. REGISTRAR'S SIGNATURE <u>Beth Bowes</u>

81 ЭКОНОМИКА-СТАТИСТИКА И ТЕХНИКА ВОДЫ СМЕСИ

SEP 13 1952

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

09946  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport (Mt. Tammany)</b>		f. STREET ADDRESS <b>Hampton Rd. West</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CLEVER</b>	First	Middle	Last	4. DATE OF DEATH <b>September 30 1957</b>	Month	Day	Year		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 5, 1898</b>	9. AGE (In years last birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months <b>11</b>	Days <b>25</b>	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vocational Instructor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland Ref. for Males</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James M. Reynolds</b>			14. MOTHER'S MAIDEN NAME <b>Lulu B. Snavely</b>			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>211-09-1784</b>		17. INFORMANT <b>Mrs. Thelma V. Reynolds Mt. Tammany</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Thrombosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerotic heart disease</b> DUE TO <b>with old infarctions</b> (c) <b>11 yrs</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Benign prostate hypertrophy</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept. 1 1957</b> to <b>Sept 30 1957</b> , that I last saw the deceased alive on <b>Sept. 29 1957</b> , and that death occurred at <b>8:17 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>317 W. Washington St Hagerstown, Md.</b>							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>		DATE SIGNED <b>10/1/57</b>							
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III M.D.</b>		21. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 10/3/1957							
22b. DATE THEREOF <b>10/3/1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>					
22e. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>		ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct. 3, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Frank Dowers</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, removal.

VS. A15ME(5)  
 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9959

09947 304  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Hancock, Md		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Along Potomac River while fishing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 0122.2	
3. NAME OF DECEASED (Type or print) BURDETT		First MIDDLE SEDDON	Last ROBERTSON
4. DATE OF DEATH Sept. 7 1957		Month Sept.	Day 7
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sept. 16, 1907
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor covering installation		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Port Royal, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert G. Robertson		14. MOTHER'S MAIDEN NAME Anna Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 17. INFORMANT 204-03-8198 Harold Potts, Central Ave., Cumberland, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490.1 DUE TO Conditions, if any, which gave rise to immediate cause (a) (b) (c) (d) (e) (f) DUE TO (b) (c) (d) (e) (f)		Acute Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED Sept. 7-57	
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/10/57 22c. NAME OF CEMETERY OR CREMATORIUM Fairview Christian Cem. 22d. LOCATION (City, town, or county) Artemas Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE SEP 13 1957	24b. REGISTRAR'S SIGNATURE <i>Ja. Kelley</i>

WEDDING EXAMINER CERTIFICATE OF BAPTISM  
STATE OF NEW YORK - BAPTISMAL

18

BUREAU U. S.  
RECEIVED  
SEP 13 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9940

## CERTIFICATE OF DEATH

09948  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Hagerstown		c. LENGTH OF STAY IN lb 22 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 1046 Georgia Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1046 Georgia Ave				d. STREET ADDRESS 1046 Georgia Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First THEODORE	Middle BENJAMIN	Last SECORD	4. DATE OF DEATH Sept 27 1957	Month 19	Doy 19	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 5 1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Secord		14. MOTHER'S MAIDEN NAME Elizabeth (last name unknown)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-7717		17. INFORMANT Mrs Viola Secord 1046 Georgia Ave		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO Cancer of prostate With generalized metastasis		INTERVAL BETWEEN ONSET AND DEATH 7 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.	20f. (City or town) Funkstown	(County) Wash. Co	(State) Md.	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, P. M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 1135 Potomac Ave		DATE SIGNED 27 Sept 1957	
ACTUAL SIGNATURE Richard T. Binford	PHYSICIAN'S NAME (Type) Richard T. Binford M.D.		Hagerstown, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/30/57	22c. NAME OF CEMETERY OR CREMATORIUM Funkstown cemetery		22d. LOCATION (City, town, or county) Funkstown Wash. Co Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Sept 30, 1957	24b. REGISTRAR'S SIGNATURE B. Powers		

## BUREAU V. 3

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9941

## CERTIFICATE OF DEATH

09949  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS 426 East Franklin St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EMMA		First	Middle	Last	4. DATE OF DEATH Sept 7 1957	Month	Day	Year 19
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 4 1875		9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frederick County Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Christian Shirley		14. MOTHER'S MAIDEN NAME Rhoda Adams						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Dorothy H. Semler 122 E. Antietam St		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost.		b. <u>Bronchopneumonia</u>		c. <u>Cerebral vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr		
						d. <u>Arteriosclerosis</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 904. Fracture of leg						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown Md.	(County)	(State)
21. I certify that I attended the deceased from <u>Sept 18</u> , 1957, to <u>Sept. 7</u> , 1957, that I last saw the deceased alive on <u>Sept. 7</u> , 1957, and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md.								
ACTUAL SIGNATURE <u>L. L. Packer Jr.</u>		M.D.		DATE SIGNED				
PHYSICIAN'S NAME (Type) L. L. Packer, Jr. M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-57		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Hoffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR Sept. 12, 1957 - G. H. Bowers		24b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81. ЭКОНОМ-РЕЖИМ СО ТВЕРДЫМ ПОДСЫПОЧНЫМ СЛОЙКОМ

## BUREAU V. 3

Sept 13 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09950  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mass. b. COUNTY Bristol	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Rt 11 south		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Bedford 58X-3	
3. NAME OF DECEASED (Type or print) FRANK MEDEIROS SENNA, JR.		d. STREET ADDRESS 693 Shawmut Ave.	
4. DATE OF DEATH September 5 1957		Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1916
9. AGE (In years last birthday) 41 yrs.	10. IF UNDER 1 YEAR 7 months	11. IF UNDER 24 HRS. 13 days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen Help		10b. KIND OF BUSINESS OR INDUSTRY Restraunt	
11. BIRTHPLACE (State or foreign country) New Bedford, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank M. Senna, Sr.		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Korean		16. SOCIAL SECURITY NO. 016-01-2495 17. INFORMANT R. Franklin Rouzer Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>353.3</u> <u>Undetermined as yet</u> INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Aspiration of vomitus			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive hemorrhage from lungs			
DUE TO (c) Probably died during convulsive seizure			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
none			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		DATE SIGNED 9-7-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/1957	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home Hagerstown, Md. <i>R. Franklin Rouzer</i>		24a. REC'D BY REGISTRAR Sept. 11, 1957	
		24b. REGISTRAR'S SIGNATURE <i>Phast. Bowers</i>	

BUREAU V.

SEP 13 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9961

## CERTIFICATE OF DEATH

09951  
Reg. Dist. No. 302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maugansville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maugansville</b>		d. STREET ADDRESS <b>1 Maugansville, Md</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maugansville, Md.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>FANNIE</b>	Middle <b>Ebersole</b>	Last <b>Shank</b>	4. DATE OF DEATH <b>Sept. 23</b>	Month <b>1957</b>	Day <b>23</b>	Year
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/6/1866</b>	9. AGE (In years last birthday) <b>90</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House keeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>@earspring, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				
13. FATHER'S NAME <b>Abram Ebersole</b>	14. MOTHER'S MAIDEN NAME <b>Fannie Horst</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Leroy Martin - Maugansville, Md.</b>	Address		INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterial occlusion, heart disease</b> 10 yrs							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Chambersburg, Pa</b>	(County) <b>Chambersburg</b>	(State) <b>Pa</b>	
21. I certify that I attended the deceased from <b>7-1-55</b> , 19 <b>19</b> , to <b>2-23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7-20-57</b> , 19 <b>19</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. E. W. Dill</b>				ADDRESS (Street, city or town, state) <b>Hanover and Chambersburg, Pa</b>			
PHYSICIAN'S NAME (Type) <b>Dr. E. W. Dill</b>				DATE SIGNED <b>9-3-57</b>			
22a. BURIAL OR CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/25/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mennonite Cem.</b>	22d. LOCATION (City, town, or county) <b>Chambersburg, Pa</b>	(State) <b>Pa</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. E. Kinnick</b>				24a. ADDRESS <b>Greencastle, Pa.</b>	24b. REC'D. BY REGISTRAR <b>Sept. 23, 1957</b>	24c. REGISTRAR'S SIGNATURE <b>Health Boarders</b>	

SEP 25 1957

REGEI VEL

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9962

### CERTIFICATE OF DEATH

09952

Reg. Dist. No.

307

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LOCUST GROVE</b>		b. COUNTY <b>WASHINGTON</b>	
c. LENGTH OF STAY IN 1b <b>72 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LOCUST GROVE RURAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROHRERSVILLE MD. R.1</b>		d. STREET ADDRESS <b>ROHRERSVILLE MD. R.1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>EMMA</b>	Middle <b>ALICE</b>	Last <b>SMITH</b>
4. DATE OF DEATH	Month <b>SEPTEMBER</b>	Day <b>16</b>	Year <b>1957</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 22 1866</b>
			9. AGE (In years lost birthday) <b>91</b>
			IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <b>9</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>TREGO WASH. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NO RECORD</b>		14. MOTHER'S MAIDEN NAME <b>SOPHIA ROHRER DICK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>IRA J. STINE ROHRERSVILLE WASH. CO. MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yr</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		<b>Generalized arteriosclerosis</b> <b>cerebral embolus</b> <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Baltimore</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Sept 15, 1957</b> to <b>Sept 16, 1957</b> , that I last saw the deceased alive on <b>Sept 16, 1957</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>G. W. LeVan</b> ADDRESS (Street, city or town, state) <b>Baltimore</b> DATE SIGNED <b>9/18/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>SEPT. 19 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>LOCUST GROVE CEMETERY LOCUST GROVE WASH. CO. MD.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bast Funeral Home Bensalem Md</b>		24a. REC'D BY REGISTRAR DATE <b>Sept. 19 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Katherine Dagenhardt</b>	

## BUREAU V.

SEP 23 1957

# REGELY ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9942

## CERTIFICATE OF DEATH

09953

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>		d. STREET ADDRESS <b>334 N. Jonathan Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>334 N. Jonathan Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George</b>		First <b>Van</b>	Middle <b>Smith</b>	Los <b>Sept</b>	DATE OF DEATH <b>8</b>	Month <b>1957</b>	Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 6 1895</b>	9. AGE (In years lost birthday) <b>62 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Upchekster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto body shop</b>		11. BIRTHPLACE (State or foreign country) <b>Williamsport, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>James E. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Merence V. Clark</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>World War I 214-09-2799</b>		17. INFORMANT <b>Mrs Gladys Smith</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO <b>023X</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>Arteriosclerotic Heart Disease and</b>		(b) <b>Arteriosclerotic Heart Disease and</b> DUE TO <b>Aortic insufficiency (luetic)</b>		(c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				6 yrs. certain 12 yrs. <b>1st</b> only	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hagerstown</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 18, 1951</b> , to <b>Sept. 8, 1957</b> , that I last saw the deceased alive on <b>August 27, 1957</b> , and that death occurred at <b>7:00A</b> M, from the causes and on the date stated above. D.S. ADDRESS (Street, city or town, state) <b>100 Professional Arts Bldg. 9-9-57</b>		DATE SIGNED					
ACTUAL SIGNATURE <b>W. T. Layman</b>		M.D. <b>W. T. Layman</b>					
PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 11 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Watson Jr.</b>		ADDRESS <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR <b>Sept 11, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Shirley Boowers</b>	

CERTIFICATE OF DEATH

BUREAU V.

SEP 13 1957

RECEIVED

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9943

### CERTIFICATE OF DEATH

09954

302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>15 Mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>830 Potomac Ave</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Conv. Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>KATIE</b>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Aug 26 1878</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (If foreign country) <b>Rockingham Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Francis Staling</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Nicewanger</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Julia Masters 830 Potomac Ave</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b>		DUE TO <b>Cerebral thrombosis</b>		Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <b>Arterio sclerosis</b>				Years			
DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>Hypertension - heart block</b>				Years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>115 W. Wash. St</b>		20f. (City or town) <b>Harrisonburg</b>		(County) <b>Rockingham Co</b>	(State) <b>Va.</b>
21. I certify that I attended the deceased from <b>Sept 24</b> , 1957, to <b>Sept 26</b> , 1957, that I last saw the deceased alive on <b>Sept 25</b> , 1957, and that death occurred at <b>8:40 A.M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Eldon D. Hoachlander</b>		M.D.		ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b>		DATE SIGNED <b>5/22/57</b>			
PHYSICIAN'S NAME (Type) <b>Eldon D. Hoachlander</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/28/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodbine Cemetery</b>		22d. LOCATION (City, town, or county) <b>Harrisonburg Rockingham Co</b>		(State) <b>Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Sept. 28, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Frank Boevers</b>			

BUREAU V. S.

OCT 1 1957

REGELY ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09955

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1		9944		2. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		3. NAME OF DECEASED (Type or print) <b>DR. JOHN HUBERT WADE</b>		4. DATE OF DEATH <b>SEPT. 21 1957</b>	
M		81		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		First <b>DR.</b> Middle <b>JOHN</b>		Month Year <b>1957</b>	
I		0		c. LENGTH OF STAY IN lb <b>4 WEEKS</b>		5. SEX <b>MALE</b>		Day Year <b>19</b>	
✓		0		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASH. CO. HOSPITAL</b>		6. COLOR OR RACE <b>WHITE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1		0		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOVEMBER 17 1872</b>		9. AGE (in years lost birthday) <b>84 yrs.</b>	
✓		0		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN GENERAL PRACTITIONER</b>		11. BIRTHPLACE (State or foreign country) <b>BOONSBORO WASH. CO. MD.</b>	
1		0		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ELI WADE</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES HARPER</b>	
✓		0		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-10-7030</b>		17. INFORMANT <b>MISS MYRA NYMAN BOONSBORO MD</b>	
1		0		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X</b>		DUE TO <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>	
✓		0		Conditions, if any, which gave rise to immediate cause (a), slothing the under- lying cause lost. (b)		DUE TO (c)			
1		0		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>old age</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
✓		0		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
1		0		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
✓		0		20f. (City or town)				(County) (State)	
1		0		21. I certify that I attended the deceased from <b>8/20</b> , 1957, to <b>9/21</b> , 1957, that I last saw the deceased alive on <b>9/21</b> , 1957, and that death occurred at <b>340 W. Main</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED <b>9/21/57</b>	
✓		0		ACTUAL SIGNATURE <b>J R Dwyer</b>		M.D.			
1		0		PHYSICIAN'S NAME (Type) <b>J R Dwyer MD</b>		<b>Hagerstown Md.</b>			
✓		0		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>ENTOMBMENT</b>		22b. DATE THEREOF <b>SEPT. 23 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>BOONSBORO MAUSOLEUM</b>	
1		0		22d. LOCATION (City, town, or county) <b>BOONSBORO WASH. CO. MD.</b>				(State)	
✓		0		23. FUNERAL DIRECTOR'S SIGNATURE <b>Best Funeral Home Boonsboro Wash. Co. Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Sept. 25, 1957</b>	
1		0						24b. REGISTRAR'S SIGNATURE <b>Street Bowes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BUREAU A

SEP 27 1957

REGELIV EBO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9945

## **CERTIFICATE OF DEATH**

09956  
Dist. No. 302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 weeks		b. COUNTY Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Convalescent Home			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown				
3. NAME OF DECEASED (Type or print) Aaron A. Wagner			d. STREET ADDRESS 405 N. Potomac St.				
First Male			Middle white	Last widowed	4. DATE OF DEATH Sept 28 1957		
5. SEX Male			6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Feb. 3, 1867		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY Machine, Tool		11. BIRTHPLACE (State or foreign country) Ringgold, Md.		
13. FATHER'S NAME Jacob F. Wagner			14. MOTHER'S MAIDEN NAME Elizabeth Manns				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 199-07-7115A		17. INFORMANT 613 S. Potomac St. Carroll H. Wagner, Waynesboro, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO cerebral vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO arteriosclerosis & anemia INTERVAL BETWEEN ONSET AND DEATH sudden (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/25/57</u> , 19 <u>57</u> , to <u>9/28/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/25/57</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u> M.D.						ADDRESS (Street, city or town, state) 136 N. Potomac St. DATE SIGNED 9/28/57	
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.			Hagerstown, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/1957		22c. NAME OF CEMETERY OR CREMATORIY Green Hill		22d. LOCATION (City, town, or county) Waynesboro, (State) Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Goss, Waynesboro, Pa.</u>			ADDRESS <u>Walter G. Goss, Waynesboro, Pa.</u>			24a. REC'D BY REGISTRAR DATE <u>9/30/1957</u>	24b. REGISTRAR'S SIGNATURE <u>Howard Powers</u>

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

## CERTIFICATE OF DEATH

1957

OCT 2 1957

RECEIVED  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9946

## CERTIFICATE OF DEATH

Reg. Dist. No. 09957302

**O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**O FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

AT 3900M TS/3-112AM TO THE INTERIOR STATE OF KUWAIT

RECEIVED  
BUREAU V. S.  
SEP 13 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9947 CERTIFICATE OF DEATH

09958307  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>MORGAN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>16 HRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON C. HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE HOLLIS WAUGH</b>		First	Middle
4. DATE OF DEATH <b>SEPT. 11 1957</b>		Month	Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>SEPT. 9 1957</b>	9. AGE (In years last birthday) yrs. <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>J</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>Morgan Co., W. Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		Address	
13. FATHER'S NAME <b>JESS W. WAUGH</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Hunter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>Wm. H. Hunter</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mongolism</b>		19. WAS AUTOPSY PERFORMED YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/10/57</b> to <b>9/11/57</b> , that I last saw the deceased alive on <b>9/11/57</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>302 N. Potowomoy St</b> DATE SIGNED <b>9/11/57</b>	
ACTUAL SIGNATURE <b>A. M. Bacon Jr.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Reburial</b>	
22b. DATE THEREOF <b>9/11/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Creechway</b>	
22d. FURNER DIRECTOR'S SIGNATURE <b>Wm. H. Hunter</b>		22e. LOCATION (City, town, or county) <b>BERKELEY SPRINGS, W. Va.</b>	
ADDRESS <b>Berkeley Springs, W. Va.</b>		24a. REC'D. BY REGISTRAR DATE <b>SEP 18 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>John H. Bowers</b>			

VS A15 (4)  
15M 9/55

9VVVVVVVYXXVV

MANHATTAN-STATE DEPARTMENT OF HIGH-TECHNOLOGY

CERTIFICATE OF DEATH

BUREAU N.Y.C.  
RECEIVED  
SEP 18 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09959

9963

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown, Md. x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 6		d. STREET ADDRESS Route 6	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDNA		First MIDDLE VIRGINIA	Last WELTY
4. DATE OF DEATH Sept. 13 1957		Month Sept.	Day 13
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH Feb. 1, 1897		9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 7 Days 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Restaurant Operator.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Rockingham County, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John W. Pittington		14. MOTHER'S MAIDEN NAME Evelyn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-20-1886	
17. INFORMANT Mr. Russell S. Welty R #6		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Another			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1957, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at _____, 1957, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md.		DATE SIGNED 1957	
ACTUAL SIGNATURE Jack H. Beachley M.D.			
PHYSICIAN'S NAME (Type) Jack H. Beachley M.D.		221 W. Washington St. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/16/57	
22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		ADDRESS 1601 Penna. Ave. Hagerstown, Md.	
24a. REC'D BY REGISTRAR Sept. 16, 1957		24b. REGISTRAR'S SIGNATURE Jack H. Beachley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 18 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9960

9948

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 33 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1001 Security Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
3. NAME OF DECEASED (Type or print) First Caroline		d. STREET ADDRESS 1001 Security Road	
4. DATE OF DEATH Sept. 1,		Month 1957	Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1888
9. AGE (In years from birth) 68		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Dys Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? Austria			
13. FATHER'S NAME Jon Tcharr		14. MOTHER'S MAIDEN NAME Maria Owolkavitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. ---	17. INFORMANT Miss Anna Yonger Hagerstown Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 1956, to Sept 1, 1957, that I last saw the deceased alive on Aug 31, 1957, and that death occurred at 7:15 PM, from the causes and on the date stated above. ACTUAL SIGNATURE Robert V. Campbell, M.D.		ADDRESS (Street, city or town, state) 145 W. Washington St. Hagerstown, Md. DATE SIGNED 9/12/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-4-57	22c. NAME OF CEMETERY OR CREMATORI Rose Hill Cemetery
22d. LOCATION (City, town, or county) Hagerstown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D. BY REGISTRAR DATE Oct. 4, 1957	24b. REGISTRAR'S SIGNATURE Robert Bowers

81. BROWNSAS—RETURN TO TWENTIETH STATE CIRCUIT 1.

SEP 6 1957

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